DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445143 | A. BUILDING _____ B. WING _____ | C 01/24/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIDGE AT ROCKWOOD, THE | 5580 ROANE STATE HWY ROCKWOOD, TN 37854 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | F 225 | **Disclaimer:**<br><br>The Bridge at Rockwood does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil of criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Melissa H Clinton | Administrator | 2/9/12 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 225 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, review of facility policy, review of facility investigation documentation, and interview, the facility failed to thoroughly investigate a report of mistreatment for two residents (#1, #6) of seven sampled residents.<br><br>The findings included:<br><br>Resident (#1) was admitted to the facility on June 1, 2010, with diagnoses including Alzheimer's Disease.<br><br>Medical record review of the Minimum Data Set (MDS) dated September 14, 2011, revealed the resident was impaired with decision-making skills, was short-tempered/easily annoyed, and free of physical or verbal aggression toward others. Medical record review of nurse's notes dated August 4, 2011, through September 29, 2011, revealed no documentation regarding aggressive behavior toward others.<br><br>Medical record review revealed no documentation regarding aggressive physical behavior between September 29, 2011, and October 25, 2011.<br><br>Medical record review of a Nursing Evaluation Tool dated October 25, 2011, at 8:25 p.m., revealed, "...observed in hallway standing in front of (resident #6) arguing...(resident #6) claimed that this resident had slung (resident #6) in the floor. This resident confirmed the accusation...taken to (resident #1's) room and 1:1 provided..." | F 225 | **Investigate/Report Allegations/Individuals**<br><br>The facility will investigate/report any allegations of mistreatment of individuals as per facility policy and federal guidelines.<br>**Residents affected:**<br>Incident reports and thorough investigations will be completed for incidents related to Resident #1 and Resident #6 by the Administrator, Director of Nursing and other relevant individuals.<br>**Residents potentially affected:**<br>Residents of the facility have the potential to be affected by this cited practice. A 100% audit of resident to resident altercation investigations for the prior 30 days will be completed by the Administrator and Director of nursing to assure that incident reports have been initiated and that investigations are thorough and complete.<br>**Systemic measures:**<br>The Administrator will educate/train the management team on the importance of initiating incident reports and conducting thorough investigations with any allegation of abuse or to rule out abuse in resident to resident altercations. Staff will be in-serviced on the Abuse policy and procedure, to include the facility's investigative process and protocol.<br>**Monitoring measures:**<br>The Administrator and DON will review for compliance, all investigations of any allegations of abuse as well as resident to resident altercations x 3 months. Any concerns identified during these audits will be addressed immediately and will also be reviewed and discussed by an interdisciplinary team in monthly QA . | 2/29/12 |

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| F 225 | Continued From page 2<br><br>Medical record review of the next nurse's note dated October 26, 2011, at 1:00 p.m., revealed, "...transferring to (hospital) ER (emergency room) due to res on res (resident on resident) altercation from previous shift." Medical record review of a nurse's note dated October 26, 2011, at 5:00 p.m., revealed the resident returned to the facility and included, "...No new orders..."<br><br>Observation on January 19, 2012, at 5:50 p.m., revealed the resident in the dining room seated at a table with other residents and free of acting-out behaviors.<br><br>Resident #6 was admitted to the facility on June 28, 2011, with diagnoses including Senile Dementia.<br><br>Medical record review of the MDS dated October 9, 2011, revealed the resident was impaired with decision-making skills, had trouble sleeping, resisted care one to three days of the assessment period, and wandered daily.<br><br>Medical record review of a "Fall/Change in in Functional Status" form dated October 25, 2011, at 8:25 p.m., revealed, "Resident observed sitting in the floor...asked if (resident) had fallen. Resident stated, 'No, (Resident #1)slung me to the floor.' Residents were immediately separated. ROM (range of motion) with no c/o (complaint) pain. Neurochecks initiated...no injuries noted..." Continued review revealed the form was completed by LPN #1.<br><br>Observation on January 24, 2012, at 10:05 a.m., | F 225 | | |

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| F 225 | Continued From page 3 | F 225 | | |

revealed the resident seated in a chair in the resident's room, rummaged through a wallet with "play" money, and was unable to respond to simple questions. The resident stated, "When was the last time I wrote you a check?"

Review of facility policy titled "Subject: Abuse, Neglect and Misappropriation" dated November, 2010, revealed, "...facility upholds resident rights and strictly prohibits verbal...physical, and mental abuse...mistreatment and neglect of residents....It is the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment...Identification...Any report or suspicion of an incident is to be reported immediately to the charge nurse. Information that should be included by the reporting person is listed...name of any witnesses to the incident...Investigation...Accident and Incident reports will be completed for: Indicators leading to suspected abuse...A thorough investigation will be initiated immediately...person(s) observing the incident will...provide a written statement with the following information:..Where the incident took place The name(s) of any witnesses to the incident...Written statements will include the date and signature, from witnesses..."

Review of facility investigation documentation dated October 25, 2011, revealed no documentation regarding an incident report and no identification and/or statement of witnesses regarding the resident to resident altercation on October 25, 2011.

Interview with Licensed Practical Nurse (LPN #1) on January 19, 2012, at 5:52 p.m., in a conference room, revealed LPN #1 was

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| F 225 | Continued From page 4<br>responsible for the documentation of the Nursing Evaluation Tool dated October 25, 2011. Continued interview revealed LPN #1 saw the resident standing over (Resident #6), LPN #1 separated the residents, and LPN #1 stated, "I heard them hollering and got a CNA (Certified Nursing Assistant)...who was working that night trying to find what caused the situation...neither resident was hurt." Continued interview revealed LPN #1 was unable to recall the identity of the CNA.<br><br>Interview with the Director of Nursing (DON) on January 24, 2012, at 10:15 a.m., in the administrator's office, revealed the facility had no incident report or additional investigation documentation regarding the altercation on October 25, 2011, and confirmed the facility failed to thoroughly investigate a resident to resident altercation for Residents #1 and #6. | F 225 | | |